DME Happenings

Jurisdiction D
June 2025

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

In this Issue

In this Issue

In this Issue

News

Ankle-Foot Orthoses/Knee-Ankle-Foot Orthoses (AFO/KAFO) Repairs

Repairs are covered when it's necessary to make the orthosis functional; meaning to fix or mend and to put back in good condition after damage or wear. There must be supporting documentation for the necessity of the repair in the physician or supplier records. If the expense for the repairs exceeds the estimated expense of providing another entire orthosis, no payment will be made for the amount in excess.

A new order is not necessary when repairing a Medicare-covered item. If the base equipment was paid for by Medicare, then the required documentation is already on file, which includes timely documentation in the medical record within the past twelve months showing that the item is being used. In the case of repairs to a beneficiary-owned AFO or KAFO, if Medicare paid for the orthosis initially, medical necessity has been established.

For a repair to be covered, the treating practitioner or supplier must document that the repair itself is reasonable and necessary, and the supplier must maintain detailed records describing the need for all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time to restore the item to its functionality.

April 2025 HCPCS Updates

CMS has released the April 2025 Healthcare Common Procedure Coding System (HCPCS) file. Inclusion on this list does not indicate coverage. All HCPCS code changes are effective and should be used for claims with dates of service on or after April 1, 2025. Please visit CMS' site to review the listing.

Watch the Noridian website for additional policy updates regarding these HCPCS codes.

Coverage Criteria for Intermittent Urinary Catheters A4353 - Immunosuppressed Beneficiaries Meeting Criteria 2

Immunosuppressed criteria for the A4353 (intermittent urinary catheter, with insertion supplies) are covered when a beneficiary requires catheterization and the beneficiary is immunosuppressed, for example below (**not an all-inclusive list**):

- On a regimen of immunosuppressive drugs post-transplant,
- On cancer chemotherapy,
- Has AIDS,
- Has a drug-induced state such as chronic oral corticosteroid use.

- High-level spinal cord injury patients will be considered for coverage for a beneficiary who has permanent urinary incontinence or permanent urinary retention that is immunosuppressed.

Please note that the above list indicates that it is not an all-inclusive list. For all conditions, the practitioner is required to clearly document the condition causing the immunosuppression within the beneficiary's medical records to qualify for criteria 2. These practitioner records must meet the medical necessity based on the coverage criteria listed within the Local Coverage Determination (LCD) L33803.

Enteral Nutrition Targeted Probe and Educate (TPE) Review

The Jurisdiction D, DME MAC, Medical Review Department conducted a Targeted Probe and Educate (TPE) review of HCPCS code(s) B4150, B4152, and B4154. The quarterly edit effectiveness results from July 2024 - September 2024 show the overall claim potential improper payment rate is **20%**. The top medical necessity denial reasons include:

- Medical record documentation does not support enteral nutrition is required to maintain weight and strength commensurate with the beneficiary's overall health status.
- Medical record documentation does not support either a full or partial non-function or disease of the structures that normally permit food to reach the small bowel; OR, disease that impairs digestion and/or absorption of an oral diet, directly or indirectly, by the small bowel.

Refer to the Enteral Nutrition Quarterly Results of Targeted Probe and Educate Review on the Noridian Medicare website for the most recent results.

External Infusion Pump Resources

The Noridian website provides a comprehensive resource page for External Infusion Pumps. This page includes links to the Local Coverage Determination (LCD), Policy Article, Clinician Letter for Medical Records, Documentation Checklist, and tips on drugs used with external infusion pumps, billing supplies when the external infusion pump is beneficiary owned, appropriate modifiers, and so much more. There are educational resources on the left-hand side of the page, which include tools relevant to the external infusion drug policy, and "Related Articles" are posted at the bottom of the page. Refer to this resource to meet your educational needs.

News

External Infusion Pumps Tool Updated and Renamed Oral and Infusion Drugs Tool

Noridian is excited to announce enhancements to the External Infusion Pumps (EIP) Tool, now renamed the Oral and Infusion Drugs Tool. This revamped tool expands its scope to include oral anticancer drugs, oral immunosuppressive drugs, intravenous immune globulin (IVIG), and external infusion pump drugs. Designed to support suppliers in accurately determining billing units for the DME MAC, the Oral and Infusion Drugs Tool is conveniently located under the Tools section of the Education and Outreach tile on the Noridian Medicare website.

Hospital Bed Resources

The Noridian website provides an all-in-one resource page for hospital beds. The page includes links to the Local Coverage Determination (LCD), Policy Article, Clinician Checklist, Clinician Letter, Documentation Checklist, and tips on billing miscellaneous code E1399, providing a pressure reducing support surface with a hospital bed, and billing instructions.

Interactive Voice Response (IVR) Authenticate Requirements

Effective June 1, 2025, Noridian's Provider Contact Center (PCC) will be able to answer up to three separate inquiries for the same National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN) combination.

To remain in compliance with self-service and authentication requirements, Noridian will ask that all provider combinations first be authenticated through the Interactive Voice Response (IVR) system. Any inquiry for an NPI or PTAN that is different than the combination already authenticated will be asked to call back and reauthenticate through Noridian's IVR.

Leg Bags for Beneficiaries Who are Ambulatory

Leg bags are designed for beneficiaries who are ambulatory, chair-bound, or wheelchair-bound, as they facilitate mobility. However, for bedridden beneficiaries, the use of leg bags is generally considered not reasonable and necessary and claims for such usage would likely be denied. This policy ensures that the appropriate medical equipment is used based on the beneficiary's mobility and needs.

News

Non-Covered Surgical Dressings

Here are some examples of wound care items that are **non-covered** under the surgical dressing benefit because they do not meet the statutory definition of a dressing:

- Skin sealants or barriers (A6250)
- Wound cleansers (A6260) or irrigating solutions
- Solutions used to moisten gauze (e.g., saline)
- Silicone gel sheets (A6025)
- Topical antiseptics
- Topical antibiotics
- Enzymatic debriding agents
- Gauze or other dressings used to cleanse or debride a wound but not left on the wound
- First-aid type adhesive bandage (A6413)
- Any item listed in the latest edition of the Orange Book (e.g., an antibiotic-impregnated dressing which requires a prescription)
- Surgical stockings (A4490, A4495, A4500, A4510)
- Non-elastic binder for an extremity (A4465)
- Small adhesive bandages (e.g., Band-Aid or similar product) are not primarily used for the treatment of wounds addressed in the Surgical Dressings policy.

Products that can't be used as primary or secondary dressings on qualifying skin wounds, or those made of materials without therapeutic or protective benefits, will be denied as statutorily non-covered, with no benefit provided. This ensures that only items meeting the specific criteria for surgical dressings are covered under the benefit.

Obtaining Prior Authorization for Bilateral Orthoses

Prior authorization requests for bilateral orthoses can be submitted on the same request. This need can be specified in the order by indicating a quantity of two, specifying right and left sides, or through medical record documentation indicating the necessity for two orthoses. However, the documentation of medical necessity must justify the requirement for bilateral braces.

Upon submission of a prior authorization request for bilateral braces, the supplier will receive two unique tracking numbers (UTNs).

The only exception to this is when a supplier is submitting a prior authorization request for bilateral mirror HCPCS codes, as the type of fitting needed at delivery may be unknown. In such cases, the supplier must submit separate prior authorization requests

for each mirror code. For example, one request for bilateral L1851 and another for bilateral L1843.

Oxygen FAQ Available

Do you have questions about oxygen and oxygen equipment? Review common questions and their answers in the collaborative Noridian and CGS Oxygen Frequently Asked Questions (FAQ) on our website.

Parenteral Nutrition Resources

The Noridian website provides a comprehensive resource page for parenteral nutrition. This page includes links to the Local Coverage Determination (LCD), Policy Article, Clinician Checklist, Documentation Checklist, and tips on billing, payment categories, pumps, modifiers, and so much more. There are educational resources on the left-hand side of the page, which includes tools relevant to the nutrition policies, and "Related Articles" are posted at the bottom of the page. Refer to this resource to meet your educational needs.

Pneumatic Compression Devices Resources

The Noridian Pneumatic Compression Devices (PCD) webpage is a one-stop shop for PCD information. Here you can find links to coverage criteria, documentation checklists, reviews, and so much more. Make our PCD webpage your top resource for PCD criteria and resources.

Required Prior Authorization (PA) Program Pre-Claim Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting pre-claim required prior authorization reviews for the below specialties. The following quarterly edit effectiveness results from January 2025 - March 2025 can be located on the Required Prior Authorization Programs webpage:

- Lower Limb Prosthetics
- Orthoses
- Power Mobility Devices
- Pressure Reducing Support Surfaces

News

Standard Written Order Requirements

To be a valid order, a Standard Written Order (SWO) requires the following elements:

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order date
- General description of the item
    - The description can be either general, a HCPCS code, a HCPCS code narrative, or a brand name/model number
- For equipment and supplies - in addition to the description of the base item, there must be a SWO for all concurrently ordered options, accessories, supplies or additional features that are separately billed or require an upgraded code. List each item separately.
- Quantity to be dispensed, when applicable
- Treating practitioner’s name or National Provider Identifier (NPI)
- Treating practitioner's signature

As a reminder, a new order is required in the following situations:

- For all claims for purchases or initial rentals
- If there is a change in the DMEPOS order (e.g., quantity)
- On a regular basis (even if there is no change in the order) when specified by the medical policy
- When an item is replaced
- When there is a change in supplier and the new supplier is unable to obtain a copy of a valid order for the DMEPOS item from the transferring supplier.

Suppliers frequently ask if a new order is needed when there is a change in the order. Our response is: If a physician writes an order with a general description (e.g., a HCPCS code) and the order still applies after the change, then no new order is needed. For more details, refer to the Standard Documentation Requirements for All Claims Billed to the DME MACs Article A55426.

Supply Allowance for Immunosuppressive Drugs

Effective for claims with dates of service (DOS) **on or after** January 1, 2025, the CMS finalized policy to allow payment of a refill of a prescription under the Immunosuppressive Drug Benefit for up to a 90-day supply. The final rule is based on individual circumstances respective of applicable State laws and regulations. A narrative is required on the claim to indicate a 90-day supply. Medical records are expected to support the need for the care provided.

For DOS **prior to** January 1, 2025, the quantity of dispensed medically necessary immunosuppressive drugs is limited to a 30-day supply.

Refer to Local Coverage Determination (LCD) L33824 for more information.

Targeted Probe and Education (TPE) Pre-Payment Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting pre-payment supplier specific reviews for the below specialties. The following quarterly edit effectiveness results from January 2025 - March 2025 can be located on the Medical Record Review Results webpage:

- Ankle-Foot Orthosis
- Enteral Nutrition
- Glucose Monitors
- Hospital Beds
- Knee Orthosis
- Manual Wheelchairs
- Ostomy Supplies
- Oxygen
- Parenteral Nutrition
- Pneumatic Compression Devices (PCD)
- Positive Airway Pressure (PAP) Devices
- Surgical Dressings
- Therapeutic Shoes
- Urological Supplies

Understanding HCPCS Code E2298 and Related Billing Guidelines

The E2298 (complex rehabilitative power wheelchair accessory, power seat elevation system, any type) is covered if a beneficiary meets the coverage criteria for either a Group 2 single power option or multiple power option power-driven wheelchair, or a Group 3 power-driven wheelchair as described in the Power Mobility Devices LCD as codes K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, and K0864 and meets the coverage criteria for seat elevation equipment as described in CMS *Medicare National Coverage Determinations (NCD) Manual* (Pub. 100-03) Chapter 1, Part 4, Section 280.16 Seat Elevation Equipment (Power Operated) on Power Wheelchairs. Below is a detailed breakdown of its usage and associated guidelines:

News

Billing Rental or Purchase Options with Correct Modifiers

The beneficiary has the option to purchase or rent the base chair. The E2298 will be billed based on the option chosen by the beneficiary for the base chair of either rental or purchase.

- **Rental Option:** Use modifiers RRBRKX for both the base chair and accessory (e.g., E2298RRBRKX).
- **Purchase Option:** Use modifiers NUBPKX for both the base chair and accessory (e.g., E2298NUBPKX).

Noncomplex Rehabilitative Power Wheelchairs: K0830 and K0831

- Usage: Codes K0830 and K0831 are designated for noncomplex rehabilitative power wheelchairs equipped with seat elevation systems. These codes must be officially verified by the PDAC (Pricing, Data Analysis, and Coding) to ensure compliance with Medicare billing requirements.
- When providing a heavy duty or very heavy-duty power wheelchair described by HCPCS codes K0824, K0825, K0826, K0827, K0828, and K0829, that could include a seat elevation system, that system, if included, would be billed separately under HCPCS code K0108 by using HCPCS codes K0824 - K0829 plus K0108 (see below).

Miscellaneous Code K0108

- **Purpose:** Use code K0108 for wheelchair components or accessories not otherwise specified. It is applicable for retrofitting power seat elevation equipment onto noncomplex rehabilitative power wheelchairs owned by beneficiaries.
- **Billing Requirements:** When using K0108, suppliers must include detailed information in the narrative field:
    - Description of the item or service
    - Manufacturer name
    - Product name, model name, and number
    - Supplier Price List (PL) amount
    - HCPCS code of related item (if applicable)
    - If repair part is repaired, the HCPCS code of item being repaired
- **Group 2 and Group 5 Bases:** K0108 can also be applied to Group 2 noncomplex heavy-duty bases (K0824, K0825, K0826, K0827, K0828, and K0829) and Group 5 power driven wheelchair bases. For instance, a K0825 wheelchair with an accessory seat elevation system can be billed using K0108.

Note: The K0108 is not included in the voluntary prior authorization review for power mobility accessories.

News

Resources

- CMS MM13658
- CMS Medicare Coverage Database
- Power Mobility NCD

Medical Policies and Coverage

2025 HCPCS Code Update - April Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2025 HCPCS Code Update - April Edition - Correct Coding**, has been created and published to our website.

View the locally hosted 2025 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Custom Fitted Orthotic HCPCS Codes Without a Corresponding Off-the-Shelf Code - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Custom Fitted Orthotic HCPCS Codes Without a Corresponding Off-the-Shelf Code - Correct Coding - Revised**, has been created and published to our website.

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Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) - Correct Coding - Revised**, has been created and published to our website.

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Medical Policies and Coverage

Dynamic Adjustable Devices, Static Progressive Stretch Devices, and Use of Modifiers - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Dynamic Adjustable Devices, Static Progressive Stretch Devices, and Use of Modifiers - Revised**, has been created and published to our website.

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July 2025 HCPCS Updates

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Watch the Noridian website for additional policy updates regarding these HCPCS codes.

LCD and Policy Article Revisions Summary for April 3, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for April 3, 2025**, has been created and published to our website.

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LCD and Policy Article Revisions Summary for April 17, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for April 17, 2025**, has been created and published to our website.

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LCD and Policy Article Revisions Summary for May 22, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for May 22, 2025**, has been created and published to our website.

View the locally hosted 2025 DMD articles.

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Lymphedema Compression Treatment Items - Correct Coding and Billing - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Lymphedema Compression Treatment Items - Correct Coding and Billing - Revised**, has been created and published to our website.

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New HCPCS Codes for Wheelchair Accessories - Coding and Billing

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **New HCPCS Codes for Wheelchair Accessories - Coding and Billing**, has been created and published to our website.

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New HCPCS Codes for Wheelchair Transportation/Transit Securement Systems - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **New HCPCS Codes for Wheelchair Transportation/Transit Securement Systems - Correct Coding**, has been created and published to our website.

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New HCPCS Codes for Wheelchair Transportation/Transit Securement Systems - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, New HCPCS Codes for Wheelchair Transportation/Transit Securement Systems – Correct Coding - Revised, has been created and published to our website.

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Policy Article Revisions Summary for March 13, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for March 13, 2025**, has been created and published to our website.

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- Locate/select article title

Policy Article Revision Summary for March 20, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revision Summary for March 20, 2025**, has been created and published to our website.

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Policy Article Revisions Summary for April 10, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for April 10, 2025**, has been created and published to our website.

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Policy Article Revisions Summary for May 29, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for May 29, 2025**, has been created and published to our website.

View the locally hosted 2025 DMD articles.

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- Locate/select article title

VYALEV® (foscarbidopa and foslevodopa), the VYAFUSER Pump, and Related Infusion Supplies - Correct Coding and Billing - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **VYALEV® (foscarbidopa and foslevodopa), the VYAFUSER Pump, and Related Infusion Supplies - Correct Coding and Billing - Revised**, has been created and published to our website.

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MLN Connects - February 28, 2025

Hospitals: Actions to Make Healthcare Prices Transparent

Update: On February 25, the White House issued an Executive Order to empower patients with clear, accurate, and actionable healthcare pricing information. Read the fact sheet for more information, which indicates the Departments of the Treasury, Labor, and Health and Human Services will:

- Ensure hospitals and insurers disclose actual prices, not estimates, and take action to make prices comparable across hospitals and insurers, including prescription drug prices
- Update their enforcement policies to ensure hospitals and insurers are in compliance with requirements to make prices transparent

Existing CMS guidance: Hospital Price Transparency regulations require each hospital operating in the U.S. to provide 1) a comprehensive machine-readable file with the standard charges for all items and services the hospital provides and 2) a display of shoppable services in a consumer-friendly format.

Additional resources available:

- Hospital Price Transparency Tools: CMS offers a suite of tools to aid hospitals in implementing hospital price transparency. These tools are designed to help facilitate compliance with regulations and enhance the accessibility of pricing information. The Online Validator ensures machine-readable files meet CMS template layouts and data specifications, enabling hospitals to identify and fix errors before publication. The HPT TXT Generator helps hospitals create the required cms-hpt.txt file, which contains information about the hospital and a direct link to the machine-readable file.
- Data Dictionary GitHub Repository: Here hospitals can access the CMS templates and data dictionary with technical instructions for encoding required standard charge information and get technical support.
- For any questions related to hospital price transparency, email PriceTransparencyHospitalCharges@cms.hhs.gov.

Compliance: CMS is planning a more systematic monitoring and enforcement approach, per the Executive Order. Consistent with standing CMS policies, non-compliance will be addressed with swift enforcement. See a list of enforcement actions to date and see a list, updated quarterly, of enforcement activities and their outcomes undertaken by CMS since the January 1, 2021, effective date.

MLN Connects

MLN Connects - March 6, 2025

MLN Connects Newsletter: March 6, 2025

News

- Therapy Services: Get Updates for CY 2025
- Hospitals: Apply for Additional Residency Positions by March 31

Compliance

- Oral Anticancer & Antiemetic Drugs: Prevent Claim Denials

Claims, Pricers & Codes

- Updated ICD-10 Medicare Severity Diagnosis-Related Group Version 42.1
- Inpatient Psychiatric Facilities Prospective Payment System: April 2025 Coding Updates

MLN Matters® Articles

- Roster Billing for Hepatitis B: July 2025 Release

MLN Connects - March 13, 2025

MLN Connects Newsletter: Mar 13, 2025

News

- Medicare Shared Savings Program: Application Deadlines for January 1, 2026, Start Date

Claims, Pricers & Codes

- ICD-10 Coordination & Maintenance Committee: Submit Procedure Code Comments by April 18

From Our Federal Partners

- CHAMPVA Claims: Enroll in Direct Deposit to Avoid a Payment Pause

MLN Connects

MLN Connects - March 25, 2025

MLN Connects Newsletter: Mar 25, 2025

News

- ESRD: Payment for Phosphate Binders Effective January 1, 2025
- Hospitals: Apply for Additional Residency Positions by March 31
- Skilled Nursing Facilities: Revalidation Deadline is May 1
- Promote Kidney Health During National Kidney Month
- Colorectal Cancer: Screening Saves Lives
- Improve Your Search Results for CMS Content

Compliance

- Bacterial Culture Lab Test: Prevent Claim Denials

Claims, Pricers & Codes

- Medicare Part B Drug Pricing Files & Revisions: April Update
- National Correct Coding Initiative: April Update
- Rural Health Clinics: Submitting Quality Reporting Category II HCPCS Codes Effective April 1

Publications & Multimedia

- Complying with Medical Record Documentation Requirements - Revised
- Medicare Coverage of Diabetes Supplies – Revised

MLN Connects - March 27, 2025

MLN Connects Newsletter: Mar 27, 2025

News

- Extension of Medicare Provisions
- Final National Coverage Determination: Transcatheter Tricuspid Valve Replacement
- Nutrition-Related Health Conditions: Recommend Medicare Preventive Services

Claims, Pricers, & Codes

- Discarded Drugs & Biologicals: Deleted HCPCS Code

MLN Connects

MLN Matters® Articles

- Clinical Laboratory Fee Schedule & Laboratory Services Subject to Reasonable Charge Payment: April 2025 Quarterly Update
- HCPCS Codes & Clinical Laboratory Improvement Amendments Edits: April 2025
- Improving Payment Accuracy for Physician Services in Skilled Nursing Facilities
- Processing Hospice Claims - Principal Diagnosis Code Reporting Update: Medicare Claims Processing Manual, Chapter 11, Sections 30.3, 40.2 & 50
- Roster Billing for Hepatitis B: July 2025 Release - Revised

Publications & Multimedia

- Hospital Price Transparency
- 2025 Medicare Part C and Part D Reporting Requirements and Data Validation – Revised

MLN Connects - April 3, 2025

MLN Connects Newsletter: April 3, 2025

News

- Home Infusion Therapy & Intravenous Immune Globulin Services: Get Monitoring Reports
- Medicare Providers & Suppliers: Report Managing Employees
- External User Services Help Desk: New Contact Information
- Advanced Primary Care Management Services: Get Information about Billing Medicare

Claims, Pricers & Codes

- Lower Limb Orthoses: Prevent Claim Denials

MLN Matters® Articles

- Rural Health Clinic & Federally Qualified Health Center Medicare Benefit Policy Manual Update

MLN Connects

MLN Connects - April 11, 2025

MLN Connects Newsletter: Apr 11, 2025

News

- Dr. Mehmet Oz Shares Vision for CMS
- Skilled Nursing Facility Value-Based Purchasing Program: March 2025 Confidential Feedback Reports
- Skilled Nursing Facilities: Revalidation Deadline is May 1

Compliance

- Pneumatic Compression Devices: Prevent Claim Denials

Claims, Pricers & Codes

- Medicare Physician Fee Schedule Database: April Update
- Integrated Outpatient Code Editor Version 26.1

MLN Matters® Articles

- ICD-10 & Other Coding Revisions to National Coverage Determinations: July 2025 Update
- DMEPOS Fee Schedule: April 2025 Quarterly Update
- Hospital Outpatient Prospective Payment System: April 2025 Update

MLN Connects - April 14, 2025

FY 2026 Proposed Payment Rules

- CMS Seeks Public Input on Inpatient Hospital Whole-Person Care, Proposes Updates to Medicare Payments
- Inpatient Rehabilitation Facility Prospective Payment System
- Hospice Wage Index & Payment Rate Update
- Inpatient Psychiatric Facility Prospective Payment System & Quality Reporting Updates
- Skilled Nursing Facility Prospective Payment System

MLN Connects

MLN Connects - April 17, 2025

MLN Connects Newsletter: Apr 17, 2025

News

- Clotting Factors: Medicare Part B Pays for Alhemo & Qfitlia
- Skilled Nursing Facilities: Revalidation Deadline Extended to August 1
- Raise Awareness & Understanding of Alcohol Use and Misuse

MLN Connects - April 24, 2025

MLN Connects Newsletter: Apr 24, 2025

News

- Open Payments: Review Your Data by May 15
- Medicare Shared Savings Program: Application Toolkit Materials

MLN Matters® Articles

- Inpatient Psychiatric Facilities: Return to Provider Claims with Point of Origin for Admission or Visit Code D & Charges for Emergency Department Services

MLN Connects - May 1, 2025

MLN Connects Newsletter: May 1, 2025

News

- Clinical Laboratory Fee Schedule Preliminary Gapfill Rates: Submit Comments by June 28

Compliance

- Acute Care Hospital Outpatient Services for Hospice Enrollees: Reduce Improper Payments
- Wheelchair Seating: Prevent Claim Denials

Events

- Clinical Laboratory Fee Schedule Annual Public Meeting - June 27

MLN Connects

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: April 2025 Update
- Clinical Laboratory Fee Schedule & Laboratory Services Subject to Reasonable Charge Payment: July 2025 Update
- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: July 2025 Quarterly Update

MLN Connects - May 8, 2025

MLN Connects Newsletter: May 8, 2025

News

- Direct Graduate Medical Education: Get Annual Update Factors

Compliance

- Walkers: Prevent Claim Denials

Events

- HCPCS Public Meeting - June 2-3
- Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests - July 23-24

Publications & Multimedia

- Medicare Preventive Services – Revised

MLN Connects - May 13, 2025

News

CMS Seeks Public Input on Improving Technology to Empower Medicare Beneficiaries

MLN Connects - May 22, 2025

MLN Connects Newsletter: May 22, 2025

News

- Discarded Drugs: Get Updated Lists
- Medicare Provider Payment & Utilization Public Use Files: Annual Update

- Medicare Fee-for-Service Geographic Variation Public Use Files & Interactive Dashboard: Annual Update
- CMS Fast Facts: Annual Update

Compliance

- Skilled Nursing Facilities: Identify & Prevent Improper Part D Payments for Drugs
- Psychiatric Care: Prevent Claim Denials

Claims, Pricers & Codes

- Medicare Physician Fee Schedule Database: July Update

MLN Connects - May 22, 2025 - Departments of Labor, Health and Human Services, Treasury Announce Move to Strengthen Healthcare Price Transparency

Trump administration issues request for information, guidance to expand access to real prices

The departments of Labor, Health and Human Services, and the Treasury took action to advance President Trump's directive to ensure Americans have clear, accurate, and actionable information about healthcare prices.

The departments jointly issued a Request for Information (RFI) seeking public input on how to improve prescription drug price transparency. The agencies also released updated guidance for health plans and issuers that sets a clear applicability date for publishing an enhanced technical format for disclosures. These improvements are designed to eliminate meaningless or duplicative data and make cost information easier for consumers to understand and use.

Separately, CMS released new guidance, available on the Hospital Price Transparency resources website, to strengthen the Hospital Price Transparency requirements, requiring hospitals to post the actual prices of items and services, not estimates. CMS also issued its own RFI to gather public feedback on how to boost hospital compliance and enforcement and ensure data shared is accurate and complete.

See the full press release for more information.

MLN Connects

MLN Connects - May 29, 2025

MLN Connects Newsletter: May 29, 2025

News

- Inpatient Hospital Admissions: Transferring Medical Review Responsibilities for Short Stay Claims
- Medicare Shared Savings Program: Apply Now

MLN Matters® Articles

- National Coverage Determination 20.36: Implantable Pulmonary Artery Pressure Sensors for Heart Failure Management
- Qualifications for Speech-Language Pathologists Providing Outpatient Speech-Language Pathology Services

From Our Federal Partners

- Providers Accepting CHAMPVA: You Must Enroll in EFT to Get Paid

MLN Matters

DMEPOS Fee Schedule: April 2025 Quarterly Update

Related CR Release Date: April 2, 2025

MLN Matters Number: MM13990

Effective Date: April 1, 2025

Related Change Request (CR) Number: CR 13990

Implementation Date: April 7, 2025

Related CR Transmittal Number: R13122CP

CR 13990 tells you about:

- New HCPCS codes
- New fee schedule amounts
- New HCPCS codes on the fee schedule file for:
    - DMEPOS repairs and servicing
    - Complex rehabilitative power wheelchair accessories
    - Lymphedema compression treatment items

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13990.

Contacts, Resources, and Reminders

Jurisdiction D DME MAC Supplier Contacts and Resources

Supplier Contact Center (SCC) - View hours of availability, call flow, authentication details and customer service areas of assistance.

Email Addresses - Suppliers may submit emails to Noridian for answers regarding basic Medicare regulations and coverage information. View this page for details and request form.

Fax Numbers - View fax numbers and submission guidelines.

Holiday Schedule - View holiday dates that Noridian operations, including customer service phone lines, will be unavailable for customer service.

Interactive Voice Response (IVR) - Self-Service Technology - View conversion tool and information on how to use IVR and what information is available through system. General IVR inquiries available 24/7.

Mailing Addresses - View mail addresses for submitting written correspondence, such as claims, letters, questions, general inquiries, enrollment applications and changes, written Redetermination requests and checks to Noridian.

DME MACs and Other Resources

Beneficiaries Call 1-800-MEDICARE

Suppliers are reminded that when beneficiaries need assistance with Medicare questions or claims that they should be referred to call 1-800-MEDICARE (1-800-633-4227) for assistance. The supplier contact center only handles inquiries from suppliers.

The table below provides an overview of the types of questions that are handled by 1-800-MEDICARE, along with other entities that assist beneficiaries with certain types of inquiries.

Organization	Phone Number	Types of Inquiries
1-800-MEDICARE	1-800-633-4227	General Medicare questions, ordering Medicare publications or taking a fraud and abuse complaint from a beneficiary
Social Security Administration	1-800-772-1213	Changing address, replacement Medicare card and Social Security Benefits

Contacts, Resources, and Reminders

Organization	Phone Number	Types of Inquiries
RRB - Railroad Retirement Board	1-800-808-0772	For Railroad Retirement beneficiaries only - RRB benefits, lost RRB card, address change, enrolling in Medicare
Coordination of Benefits - Benefits Coordination & Recovery Center (BCRC)	1-855-798-2627	Reporting changes in primary insurance information

Another great resource for beneficiaries is the website, Medicare.gov, where they can:

- Compare hospitals, nursing homes, home health agencies, and dialysis facilities
- Compare Medicare prescription drug plans
- Compare health plans and Medigap policies
- Complete an online request for a replacement Medicare card
- Find general information about Medicare policies and coverage
- Find doctors or suppliers in their area
- Find Medicare publications
- Register for Medicare.gov

As a registered user of MyMedicare.gov, beneficiaries can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card
- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

"This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents."

Contacts, Resources, and Reminders

Sources for "DME Happenings" Articles

The purpose of "DME Happenings" is to educate Noridian's Durable Medical Equipment supplier community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever Noridian publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes "Source" following CMS derived articles to allow for those interested in the original material to research it on the CMS Manuals webpage. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled "MLN Matters," which will continue to be published in Noridian bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

Automatic Mailing/Delivery of DMEPOS Reminder

Suppliers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS.

A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore, the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. Again, the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

Source: Internet Only Manual (IOM), Publication 100-4, Medicare Claims Processing Manual, Chapter 20, Section 200

Contacts, Resources, and Reminders

CERT Documentation

This article is to remind suppliers they must comply with requests from the Comprehensive Error Rate Testing (CERT) Review Contractor (RC) for medical records needed for the CERT program. An analysis of the CERT related appeals workload indicates a common reason for the appeal is due to "no submission of documentation" and "submitting incorrect documentation."

Suppliers are reminded the CERT program produces national, contractor-specific and service-specific paid claim error rates, as well as a supplier compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The supplier compliance error rate is a measure of the extent to which suppliers are submitting claims correctly.

The CERT RC sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CERT RC will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT RC via fax, the preferred method, or mail. Please see the CERT RC website for contact information at C3HUB.

Note: The CID number is the CERT reference number contained in the documentation request letter.

Suppliers may call the CERT RC with questions regarding specific documentation to submit.

Suppliers must submit medical records within 60 days from the receipt date of the initial letter or claims will be denied. The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims.

Medicare patients have already given authorization to release necessary medical information in order to process claims. Therefore, Medicare suppliers do not need to obtain a patient's authorization to release medical information to the CERT RC.

Suppliers who fail to submit medical documentation will receive claim adjustment denials from Noridian as the services for which there is no documentation are interpreted as services not rendered.

Contacts, Resources, and Reminders

Physician Documentation Responsibilities

Suppliers are encouraged to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity (CMN). It is the physician's and supplier's responsibility to determine the medical need for, and the utilization of, all health care services. The physician and supplier should ensure that information relating to the beneficiary's condition is correct. Suppliers are also encouraged to include language in their cover letters to physicians reminding them of their responsibilities.

Source: CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.5

Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Overpayment Refund Form found on the Forms page of the Noridian DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form which Noridian has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Overpayment Refund Form instructions.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient's name, Medicare number or claim number information is not provided, no appeal rights can be afforded.

Suppliers are also reminded that "The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

Source: Transmittal 50, Change Request 3274, dated July 30, 2004

Telephone Reopenings: Resources for Success

This article provides the following information on Telephone Reopenings: contact information, hours of availability, required elements, items allowed through Telephone Reopenings, those that must be submitted as a redetermination, and more.

Per the CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 34, Section 10, reopenings are separate and distinct from the appeals process. Contractors should note that while clerical errors must be processed as reopenings, all decisions on granting reopenings are at the discretion of the contractor.

Section 10.6.2 of the same Publication and Chapter states a reopening must be conducted within one year from the date of the initial determination.

How do I request a Telephone Reopening?

To request a reopening via telephone, call 1-877-320-0390.

What are the hours for Telephone Reopenings?

Monday - Friday 8 a.m. - 6 p.m. CT

Closures:

- Holiday Schedule
- Training Closures

What information do I need before I can initiate a Telephone Reopening?

Before a reopening can be completed, the caller must have all of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed.

Verified by Customer Service Representative (CSR) or IVR:

- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- Last five digits of Tax Identification Number (TIN)

Verified by CSR:

- Caller's name
- Provider/Facility name
- Beneficiary Medicare number
- Beneficiary first and last name
- Date of Service (DOS)
- Last five digits of Claim Control Number (CCN)
- HCPCS code(s) in question
- Corrective action to be taken

Claims with remark code MA130 can **never** be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

What may I request as a Telephone Reopening?

The following is a list of clerical errors and omissions that may be completed as a Telephone Reopening. **Note:** This list is not all-inclusive.

- Diagnosis code changes or additions
- Date of Service (DOS) changes
- HCPCS code changes
- Certain modifier changes or additions (not an all-inclusive list)

If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation.

What is not accepted as a Telephone Reopening?

The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation:

- Overutilization denials that require supporting medical records
- Certificate of Medical Necessity (CMN) issues (applies to Telephone Reopenings only)
- Durable Medical Equipment Information Form (DIF) issues (applies to both Written and Telephone Reopenings)
- Oxygen break in service (BIS) issues
- Overpayments or reductions in payment. Submit request on Overpayment Refund Form
- Medicare Secondary Payer (MSP) issues
- Claims denied for timely filing (older than one year from initial determination)
- Complex Medical Reviews or Additional Documentation Requests (ADRs)
- Change in liability
- Recovery Auditor-related items
- Certain modifier changes or additions: EY, GA, GY, GZ, K0 - K4, KX, RA (cannot be added), RB, RP
- Certain HCPCS codes: E0194, E1028, K0108, K0462, L4210, All HCPCS in Transcutaneous Electrical Nerve Stimulator (TENS) LCD, All National Drug Codes (NDCs), miscellaneous codes and codes that require manual pricing

The above is not an all-inclusive list.

Contacts, Resources, and Reminders

What do I do when I have a large amount of corrections?

If a supplier has at least 10 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information for the supplier to submit a Special Project.

Where can I find more information on Telephone Reopenings?

- Supplier Manual Chapter 12
- Reopening webpage
- CMS IOM, Publication 100-04, Chapter 34

Additional assistance available

Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Emails containing Protected Health Information (PHI) will be returned as unprocessable.